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The End of “Bona Fide Wellness Programs”

You may have heard by now that “Nondiscrimination and Wellness Programs in Health Coverage in the Group Market; Final Rules” were published Dec. 13, 2006 in the Federal Register. These are better known as the HIPAA rules that specify requirements for a “bona fide wellness program.” Oddly enough, one of the changes in the final rules is to stop using the term “bona fide wellness program.” What else has changed and what hasn’t? Read on – you might be surprised about a couple items.

What has not changed?

The final rules still allow health plans to vary employee premium contributions or benefit levels (such as a deductible, copayment, or coinsurance) across similarly situated individuals based on a health factor only in connection with wellness programs. Did you know that the proposed rules allowed plan sponsors to make deductible, copayment and coinsurance distinctions based upon health factors and didn’t just limit differences to premium contributions? They did, and the final rules do too.

In other words, you can still offer discounts on health plan costs and/or different benefit levels based on a health factor, **as long as you also offer a wellness program that will help people to achieve the health factor.** Health factors still include: health status; medical condition, including both physical and mental illnesses; claims experience; receipt of health care; medical history; genetic information; evidence of insurability; and disability.

What has changed?

The final rules are pretty consistent with the 1997 interim rules and the 2001 proposed rules on “bona fide” wellness programs. However, details do matter when it comes to compliance issues. The final rules include a few subtle changes and clarifications to the earlier rules:

Say goodbye to “bona fide.” The final rules treat all programs of health promotion or disease prevention as “wellness” (minus ‘bona fide’) programs and specify that (1) if no reward is offered or (2) if none of the conditions for obtaining a reward is based on an individual satisfying a standard related to a health factor, the program does not have to satisfy additional requirements. The rules provided these new examples of programs that do not have to satisfy additional requirements:

- A program that reimburses all or part of the cost for memberships in a fitness center.
- A diagnostic testing program that provides a reward for participation rather than outcomes.
- A program that encourages preventive care by waiving the copayment or deductible requirement for the costs of, for example, prenatal care or well-baby visits.
- A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.
- A program that provides a reward to employees for attending a monthly health education seminar.

Say hello to one more requirement for wellness programs (although it may look familiar):

	Five Requirements	Changes from earlier rules
1.	The total reward for all the plan's wellness programs that require satisfaction of a standard related to a health factor generally must not exceed 20% of the cost of employee-only coverage under the plan. If dependents (such as spouses and/or dependent children) may participate in the wellness program, the reward must not exceed 20% of the cost of the coverage in which an employee and any dependents are enrolled. This dependent language is new.	Specifies 20% limit and adds information about dependents.
2.	<p>The program must be reasonably designed to promote health and prevent disease. To clarify that the requirement is intended to be an easy standard to satisfy, the final rules state, "If a program has a reasonable chance of improving the health of participants and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease, it satisfies this standard.</p> <p>There does not need to be a scientific record that the method promotes wellness to satisfy this standard. The standard is intended to allow experimentation in diverse ways of promoting wellness. For example, a plan or issuer could satisfy this standard by providing rewards to individuals who participated in a course of aromatherapy. The requirement of reasonableness in this standard prohibits bizarre, extreme, or illegal requirements in a wellness program."</p>	Adds clarification about definition of a "reasonably designed" program.
3.	The program must give individuals eligible to participate the opportunity to qualify for the reward at least once per year.	This requirement used to be part of the second requirement.
4.	<p>The reward must be available to all similarly situated individuals. The program must allow a reasonable alternative standard (or waiver of initial standard) for obtaining the reward to any individual for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the initial standard.</p> <p>A program does <u>not</u> need to establish the specific reasonable alternative standard before the program begins. It is fine to establish the standard after the employer finds out that someone needs an alternative standard. In addition, plans may seek verification, such as a statement from a physician, that a health factor makes it unreasonably difficult or medically inadvisable for an individual to meet a standard.</p>	Clarifies when alternative standard needs to be developed.
5.	The plan must disclose in all materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of a waiver of the initial standard).	Includes sample language for disclosing availability of a reasonable alternative.

So what does this mean for you?

If you are offering discounts on the health plan costs or different benefit levels based on a health factor, you must provide a reasonable alternative standard and publish the availability of the standard in all materials describing the program. For example, if you are offering reduced health plan premiums to employees that achieve a specific Body Mass Index (BMI) level, you need to offer an alternative option that will help people maintain or reduce BMI.

In addition, you need to at least communicate the following statement, "If it is unreasonably difficult due to a medical condition if it is medically inadvisable for you to attempt to achieve the standards for the reward

under this program, call us at [insert number] and we will work with you to develop another way to qualify for the reward." You are not required to explain the alternative standard at this time. As long as people meet the standard or an alternative standard (i.e. attending 10 educational sessions and/or getting at least 30 minutes of physical activity five days a week), you must provide the reduced premium or higher benefit level.

The reduction in the premium must not exceed 20% of the cost of employee-only coverage under the plan (if dependents may participate in the wellness program, the reward must not exceed 20% of the cost of the coverage in which an employee and any dependents are enrolled) and people must be able to qualify at least once per year.

The new rules will be effective on the first day of the plan year beginning on or after July 1, 2007. Until this date, plans and issuers are required to comply with the corresponding sections of the regulations previously published in the Federal Register.

If you have additional questions about these new rules or would like assistance in helping your company achieve compliance, please contact Melissa Stankus at 440/892-2600 extension #4.